Life/Accidental Death & Dismemberment
Beneficiary Designation

Policy no. FLX-963274
Group policyholder or participating employer: City of Gulfport
Name of Insured:_____

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM.
Give FULL names and relationships of each beneficiary. If beneficiary is not related, also provide date of birth and Social Security number.

PRIMARY BENEFICIARY(IES): All beneficiaries named in this section will be considered primary. Proceeds will be paid in equal shares to these primary beneficiaries who survive you unless you indicate percentages. Percentages must equal 100%.*

Name (last, first, m.i)	Relationship to insured	Address	Date of Birth

SECONDARY BENEFICIARY(IES): If no primary beneficiaries survive you, proceeds will be paid to the surviving secondary beneficiaries names in this section. Payment will be paid in equal shares unless you indicate percentages. Percentages must equal 100%.

Name (last, first, m.i.)	Relationship to Insured	Address	Date of Birth

ANY AMOUNT OF INSURANCE PAYABLE AT MY DEATH SHALL BE PAYABLE AS INDICATED ABOVE.
***If any Primary or Secondary Beneficiary's share is a percentage of the total proceeds, and that beneficiary predeceases the Insured, then that beneficiary's share will be distributed equally among the other surviving beneficiaries within the same primary or secondary designation, unless the insured indicates otherwise in writing.**

Signature_____Date_____

Received and recorded by_____Date_____